KAMALA D. HARRIS
Attorney General of California
GLORIA A. BARRIOS
Supervising Deputy Attorney General
LINDA L. SUN
Deputy Attorney General
State Bar No. 207108
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-6375
Facsimile: (213) 897-2804
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TERESA VALDERRAMA CACHO** **14729 Madris Avenue** **Norwalk, CA 90650** **Registered Nurse License No. 510502** Respondent.	Case No. 2013-564 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about April 10, 1995, the Board issued Registered Nurse License Number 510502 to Teresa Valderrama Cacho (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

///

///

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

COST RECOVERY PROVISION

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being

renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

PATIENT D.G.

11. From 1997 to 2010, Respondent was employed as a registered nurse at the Metropolitan State Hospital in Norwalk, California. On or about January 29, 2010, Respondent was assigned as the Shift Lead (Charge Nurse) in Unit 418 to care for Patient D.G. Her primary responsibilities included, but were not limited to, patient assessment, working the floor, carrying out physician's orders, patient care, supervising other nurses, staff development, and providing faculty training.

12. At about 0930 hours, while handling Patient D.G.'s incontinent care, RNs Lopez and Concepcion noted that Patient D.G. was making rapid and shallow breathings with his mouth, his lips were slightly bluish in color, his skin color was pale, and his hands were cold to touch. They also noted that the patient's abdomen was tender and bloated. His stool was blackish, soft and with a foul odor. During the incontinent care, RNs Lopez and Concepcion noted Patient D.G. to have a syncopal episode, briefly losing consciousness and then recovering. The patient's vital signs at 0930 hours were: pulse 104; respirations 24; blood pressure 124/74; and his oxygen saturation (O2 sat.) was 89% with room air. RN Concepcion obtained and administered 2 liters of oxygen to Patient D.G. via nasal cannula. At about 0940 hours, RN Lopez notified Dr. Tuyen Le, the attending physician, of the patient's change in condition. Respondent was with Dr. Le in a meeting at the time. Dr. Le instructed Respondent to call 911. Respondent initiated the call but was directed by Dr. Le to cancel the call after he examined the patient. Dr. Le ordered hourly vital sign readings until 1400 hours.

13. At about 1100 hours, Dr. Le ordered laboratory works to be performed.

14. At about 1140 hours, RN Concepcion documented Patient D.G.'s condition and vital signs which she observed and measured at 0930 hours.

15. The following are Patient D.G.'s laboratory results and vital sign readings taken by a psychiatric technician/treatment nurse:

///

a. At about 0945 hours, pulse 104, respiration 24, O2 sat. 96;

b. At about 1045 hours, pulse 121, respiration 28, O2 sat. 94;

c. At about 1145 hours, pulse 128, respiration 44. O2 sat. 95;

d. At about 1243 hours, white blood cell count 30.3 [lab results];

e. At about 1245 hours, pulse 102, respiration 26, O2 sat. 85-87%;

f. At about 1345 hours, pulse 132, respiration 32, O2 sat. 77%.

16. At about 1330 hours, Dr. Le ordered the patient to be transferred to Norwalk Community Hospital's Emergency Department.

17. At about 1430 hours, Patient D.G. was transported to Norwalk Community Hospital for abdominal pain and respiratory distress.

18. At about 2314 hours, Patient D.G. expired due to respiratory failure secondary to hypotension/sepsis after intubation.

19. On or about March 24, 2010, during a recorded interview by an investigator for the Department of Mental Health at the Metropolitan State Hospital, Respondent stated the following:

a. At about 1130 hours, Respondent assisted the laboratory technician to obtain Patient D.G.'s blood work. Respondent documented her description of Patient D.G.'s physical status and the laboratory work order in the Interdisciplinary Notes (IDN).

b. At about 1243 hours, after the laboratory results came back high, Respondent notified Dr. Le of the white blood cell count and went on break.

c. Respondent denied she was notified by the psychiatric technician/treatment nurse of Patient D.G.'s vital signs at every hour but admitted she was informed of the O2 saturation rate.

d. Respondent did not assign anyone to document treatment or changes in the patient's condition.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1442, in that on or about January 29, 2010, she committed gross negligence in her care of Patient D.G. Complainant

refers to and incorporates all the allegations contained in paragraphs 11 – 19, as though set forth fully, and as follows:

a. Respondent failed to timely document the critical lab results and the information of Patient D.G.'s vital signs given to her by the psychiatric technician or the treatment nurse.

b. Respondent failed to ensure:

(i) all appropriate steps were taken to stabilize Patient D.G.'s O2 saturation rate and vital signs;

(ii) all documentation was completed;

(iii) the hospital's protocol for activation of an emergency response was followed.

c. Respondent failed to:

(i) make clear and comprehensive staff assignments;

(ii) follow up to see if the newly ordered treatment (O2 at 2L via nasal cannula) was effective;

(iii) follow up to ensure that the initial assessment of the patient's clinical condition which prompted Dr. Le and herself to be notified (at about 0940 hours) was documented contemporaneously;

(iv) ensure that she was not only notified of all subsequent vital sign measurements but they, too, were documented contemporaneously;

(v) contact Dr. Le and the Hospital Service Specialist when the patient's respiration rate and pulse continued to be above normal and when the patient's O2 saturation dropped to 85%.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

21. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), in conjunction with California Code of Regulations, title 16, section 1443, in that on or about January 29, 2010, she demonstrated incompetence in her care of Patient D.G. Complainant refers to and incorporates all the allegations contained in paragraphs 11 – 20, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 510502, issued to Teresa Valderrama Cacho;

2. Ordering Teresa Valderrama Cacho to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 18, 2013

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2012507703
51190740.doc